SERFF Tracking Number:	*NALH-126380103*	*State:*	*Arkansas*
Filing Company:	*Midland National Life Insurance Company*	*State Tracking Number:*	*44115*
Company Tracking Number:	*FORM 81-36 (10-09) ET AL*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Form 81-36 (10-09) et al*		
Project Name/Number:	*Form 81-36 (10-09) et al/Form 81-36 (10-09) et al*		

Filing at a Glance

Company: Midland National Life Insurance Company

Product Name: Form 81-36 (10-09) et al	SERFF Tr Num: NALH-126380103	State: Arkansas
TOI: L08 Life - Other	SERFF Status: Closed-Approved-Closed	State Tr Num: 44115
Sub-TOI: L08.000 Life - Other	Co Tr Num: FORM 81-36 (10-09) ET AL	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Author: Sherry M. Olson	Disposition Date: 11/18/2009
	Date Submitted: 11/17/2009	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: Form 81-36 (10-09) et al	Status of Filing in Domicile: Authorized
Project Number: Form 81-36 (10-09) et al	Date Approved in Domicile: 11/16/2009
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 11/18/2009	Explanation for Other Group Market Type:
	State Status Changed: 11/18/2009
Deemer Date:	Created By: Sherry M. Olson
Submitted By: Sherry M. Olson	Corresponding Filing Tracking Number:

Filing Description:

RE: Midland National Life Insurance Company
NAIC #66044 FEIN # 46-0164570

Regular Issue Application for Life Insurance Form 81-36 (10-09)
Simplified Issue Application for Life Insurance Form 81-38 (10-09)
Application for Policy Reinstatement or Change Form 81-47 (10-09)
Statement of Health Form 81-48 (10-09)

We are filing the referenced forms for your review and approval. These forms are laser printed and we reserve the right

to change fonts and layouts. We certify that the font size will never be less than the minimum 10-point required by your state.

These application forms will be used to apply for Midland's approved individual life insurance policies available in the bank- or corporate-owned life insurance market.

Regular Issue Application Form 81-36 (10-09) will replace Form 81-36 (4-05) which was approved by your department on 5/13/2005. It will be used to apply for fully underwritten products. In addition to minor language changes throughout the form, the primary differences are:

•On page 1 we added a question to allow applicants to designate a secondary addressee

•On page 2, we reformatted:

*The Details for questions 12-19 to include separate columns for Question Number, Date and Details.

*Question 20 to provide separate columns for Relationship to Proposed Insured, Condition, Current Age and Age at Death.

•On page 3:

*We added questions for the Name and Address of the physician most recently consulted, the date and reason for most recent consultation and a list of currently prescribed medications.

*We updated the content of questions 2 and 3 and revised several items to refer to "disease or disorder".

*We reformatted question 5 to provide separate columns for Question Number; Condition/Diagnosis; Approximate Dates/Duration; Treatment; Physician Name & Address.

•On page 4:

*We added a Taxpayer Identification Number Certification.

*We revised the Agent Certification to add a specific question regarding the insured's existing insurance.

•We removed a page containing the Fair Credit Reporting Act Notification, Notice of Insurance Information Practices and the Medical Information Bureau Notification. These notices will be provided to the applicant on a separate form (new Form 81-57 (10-09) that is not part of the application) A copy of Form 81-57 (10-09) is included on an informational basis but is not filed for approval.

Simplified Issue Application Form 81-38 (10-09) will replace Form 81-38 (1-05) which was approved by your department on 2/17/05. It will be used to apply for products that use simplified issue underwriting. In addition to minor language and capitalization changes throughout the form, the primary differences are:

•On page 1

*We added a question to allow applicants to designate a secondary addressee

*We added a separate question regarding the applicant's existing life insurance and annuity contracts.

*We added additional conditions to questions 16-18.

*We added questions for the Name and Address of the physician most recently consulted, the date and reason for most recent consultation and a list of currently prescribed medications.

•On page 2

SERFF Tracking Number:	*NALH-126380103*	*State:*	*Arkansas*
Filing Company:	*Midland National Life Insurance Company*	*State Tracking Number:*	*44115*
Company Tracking Number:	*FORM 81-36 (10-09) ET AL*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Form 81-36 (10-09) et al*		
Project Name/Number:	*Form 81-36 (10-09) et al/Form 81-36 (10-09) et al*		

*We added a Taxpayer Identification Number Certification.

*We updated the Fraud Statement to be consistent with our other application forms.

*We revised the Agent Certification to add a specific question regarding the insured's existing insurance.

•We removed a page containing the Fair Credit Reporting Act Notification, Notice of Insurance Information Practices and the Medical Information Bureau Notification. These notices will be provided to the applicant on a separate form (new Form 81-57 (10-09) that is not part of the application. A copy of Form 81-57 (10-09) is included on an informational basis but is not filed for approval.

Form 81-47 (10-09) will replace Form 81-47 (3-07) which was approved by your department on 3/12/2007. It will be used to apply for changes or reinstatements of existing Midland policies. In addition to minor language and capitalization changes throughout the form, the primary differences are:

•On page 1, we moved the family history question from page 2 to page 1.

•On page 2:

*We added questions for the Name and Address of the physician most recently consulted, the date and reason for most recent consultation and a list of currently prescribed medications.

*We updated the content of questions 2 and 3 and revised several items to refer to "disease or disorder".

*We reformatted question 5 to provide separate columns for Question Number; Condition/Diagnosis; Approximate Dates/Duration; Treatment; Physician Name & Address.

•On page 3:

*We revised the second paragraph to better reflect the application is for policy change or reinstatement.

*We added a Taxpayer Identification Number Certification and removed the customer notice regarding the Patriot Act.

•We removed a page containing the Fair Credit Reporting Act Notification, Notice of Insurance Information Practices and the Medical Information Bureau Notification. These notices will be provided to the applicant on a separate form (new Form 81-57 (10-09) that is not part of the application. A copy of Form 81-57 (10-09) is included on an informational basis but is not filed for approval.

Statement of Health and Insurability Form 81-48 (10-09) is a new form. It will be used when a policy is being issued beyond its delivery period or in situations when the application becomes aged based on the date of signatures.

These forms were approved by Midland's domicile state of Iowa on 11/16/2009.

If you need any additional information to complete your review, please feel free to contact me at 800-283-5433, ext. 36223 or at solson@sfgmembers.com.

Sincerely,

Sherry Olson, AIRC
Senior Contract Analyst

SERFF Tracking Number:	*NALH-126380103*	*State:*	*Arkansas*
Filing Company:	*Midland National Life Insurance Company*	*State Tracking Number:*	*44115*
Company Tracking Number:	*FORM 81-36 (10-09) ET AL*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Form 81-36 (10-09) et al*		
Project Name/Number:	*Form 81-36 (10-09) et al/Form 81-36 (10-09) et al*		

Corporate Markets Center
Midland National Life Insurance Company &
North American Company for Life & Health

Company and Contact

Filing Contact Information

Sherry Olson, Senior Contract Analyst	solson@mnlife.com
2000 44th St. South, Suite 300	701-433-6223 [Phone]
Fargo, ND 58103	701-433-8223 [FAX]

Filing Company Information

Midland National Life Insurance Company	CoCode: 66044	State of Domicile: Iowa
525 W. Van Buren Street	Group Code: 431	Company Type: Life and Annuity
Chicago, IL 60607	Group Name:	State ID Number:
(800) 800-3656 ext. [Phone]	FEIN Number: 46-0164570	

Filing Fees

Fee Required?	Yes
Fee Amount:	$80.00
Retaliatory?	No
Fee Explanation:	$20 per form x 4 forms
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Midland National Life Insurance Company	$80.00	11/17/2009	32111026

SERFF Tracking Number:	*NALH-126380103*	*State:*	*Arkansas*
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Product Name:	*Form 81-36 (10-09) et al*		
Project Name/Number:	*Form 81-36 (10-09) et al/Form 81-36 (10-09) et al*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	11/18/2009	11/18/2009

SERFF Tracking Number:	*NALH-126380103*	*State:*	*Arkansas*
Filing Company:	*Midland National Life Insurance Company*	*State Tracking Number:*	*44115*
Company Tracking Number:	*FORM 81-36 (10-09) ET AL*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Form 81-36 (10-09) et al*		
Project Name/Number:	*Form 81-36 (10-09) et al/Form 81-36 (10-09) et al*		

Disposition

Disposition Date: 11/18/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*NALH-126380103*	*State:*	*Arkansas*
Filing Company:	*Midland National Life Insurance Company*	*State Tracking Number:*	*44115*
Company Tracking Number:	*FORM 81-36 (10-09) ET AL*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Form 81-36 (10-09) et al*		
Project Name/Number:	*Form 81-36 (10-09) et al/Form 81-36 (10-09) et al*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Form 81-57 (10-09), Consumer Notices		Yes
Form	Regular Issue Application for Life Insurance		Yes
Form	Simplified Issue Application for Life Insurance		Yes
Form	Application for Policy Reinstatement or Change		Yes
Form	Statement of Health and Insurability		Yes

SERFF Tracking Number:	*NALH-126380103*	*State:*	*Arkansas*
Filing Company:	*Midland National Life Insurance Company*	*State Tracking Number:*	*44115*
Company Tracking Number:	*FORM 81-36 (10-09) ET AL*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Form 81-36 (10-09) et al*		
Project Name/Number:	*Form 81-36 (10-09) et al/Form 81-36 (10-09) et al*		

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	Form 81-36 (10-09)	Application/ Enrollment Form	Regular Issue Application for Life Insurance	Initial		50.800	81-36 (10-09).pdf
	Form 81-38 (10-09)	Application/ Enrollment Form	Simplified Issue Application for Life Insurance	Initial		50.300	81-38 _10-09_.pdf
	Form 81-47 (10-09)	Application/ Enrollment Form	Application for Policy Reinstatement or Change	Initial		50.900	81-47 _10-09_.pdf
	Form 81-48 (10-09)	Application/ Enrollment Form	Statement of Health and Insurability	Initial		53.300	Midland Form 81-48 _10-09_.pdf

MIDLAND NATIONAL®
Life Insurance Company
A Member of the Sammons Financial Group

Regular Issue
Application for Life Insurance -- Part 1

1. Name of Proposed Insured (First, Middle and Last)	Birth date	Birthplace	Sex	Marital Status

2. Residence Address (Street, City, State, Zip)	Social Security No.	Height	Weight
		ft. in.	Lbs.

2a. Secondary Addressee (Name, Street, City, State, Zip)

3. Occupation (Title and Duties) Gross Annual Compensation $	Telephone Numbers (Home) (Bus)
4. Owner Name (If Trust, Name and Date of Trust)	Social Security or Tax ID No.
Owner Address (Street, City, State, Zip)	Relationship to proposed Insured
5a. Beneficiary	5b. Relationship
6a. Plan Applied for	6b. Sub-account (If Applicable)

6c. Amount Applied for $	6d. Death Benefit Option: ❒ 1 Level ❒ 2 Increasing ❒ Other _____
7. Changes to existing Midland policy # _____ Describe:	8. Additional Benefits:
9a. Premium $	9b. Premium Mode ❒ Single ❒ Annual ❒ Other

10. Are you a U.S. citizen? ❒ Yes ❒ No **(complete appropriate questionnaire)**

11a. Do you have existing annuity contracts or life insurance policies? ❒ No ❒ Yes **(If "Yes," complete 11b.)**

11b. Policies in Force:

Company	Face Amount	Indicate Personal	Indicate Business	Intention of Replacement or Change	
		❒	❒	❒ Yes	❒ No
		❒	❒	❒ Yes	❒ No
		❒	❒	❒ Yes	❒ No
		❒	❒	❒ Yes	❒ No

11c. Policies Applied for / Indicate Below or ❒ None:

Company	Amount	Net Amount at Risk	Indicate Personal	Indicate Business
			❒	❒
			❒	❒
			❒	❒
			❒	❒

MIDLAND NATIONAL LIFE INSURANCE COMPANY
PRINCIPAL OFFICE • WEST DES MOINES, IA 50266
CORPORATE MARKETS CENTER • 2000 44TH STREET SOUTH, STE. 300 • FARGO, ND 58103
PHONE (800) 283-5433 • FAX: (701) 433-8596

Provide details for all "Yes" answers to questions 12-19 below.

Yes	No		Yes	No	
❒	❒	12. Do you intend to travel outside the U.S. or Canada within the next 2 years? **(If "Yes", complete appropriate questionnaire.)**			17. Within the past 10 years, have you been convicted of or pled guilty to:
			❒	❒	a) Moving violations?
			❒	❒	b) Driving under the influence of alcohol and/or drugs?
❒	❒	13. Do you participate or do you intend to participate in aviation related sports, powered or competitive vehicle racing, sky or scuba diving, mountain climbing, or any other hazardous sport or activity? **(If "Yes", complete appropriate questionnaire.)**	❒	❒	18. Have you been a pilot or crew member during the past 3 years or have any intention of becoming a pilot, student pilot, or crew member in any type of aircraft? **(If "Yes", complete appropriate questionnaire.)**
❒	❒	14. Have you ever been convicted of, or are you awaiting trial for, a felony?	❒	❒	19. Have you ever used: a) Cigarettes? Date last used: _____ b) Other nicotine products: Date last used: _____
❒	❒	15. Have you ever had an application for insurance declined, postponed or rated?			
		16. Your driver's license #: _____ State: _____			

Details for questions 12-19 (include dates):

Question Number	Date	Details

20. ❒ Yes ❒ No Do you have any family history of heart disease, cancer, high blood pressure, diabetes, hemophilia, Huntington's chorea, polycystic kidney disease, or any congenital disorder? If "Yes," give details, including relationship, condition, current age, or age at death.

Relationship to Proposed Insured	Condition	Current Age	Age at Death

Home Office Endorsements

1a. Name and address of Personal Physician:

1b. Date and reason last consulted:

1c. Name and Address of physician **most recently** consulted if different than above:

1d. Date and reason for most recent consultation:

1e. List any currently prescribed medications:

2. Have you ever had or been treated for:

Yes	No	
❒	❒	a. Elevated cholesterol, high blood pressure, transient ischemic attack (TIA), stroke or circulation disorder?
❒	❒	b. Chest pain, heart attack, heart murmur, irregular heart rate, or other disease or disorder of the heart?
❒	❒	c. Cancer, tumor, polyp, blood or immune system disease or disorder?
❒	❒	d. Diabetes, kidney, or urinary disease or disorder?
❒	❒	e. Crohn's disease, colitis, ulcer, diverticulitis, hepatitis, or any disease of the esophagus or liver?
❒	❒	f. Sleep apnea, asthma, emphysema, lung or respiratory disease or disorder?
❒	❒	g. Depression, mental illness, anxiety or seizure disorder?
❒	❒	h. Breast, uterus, ovaries, testicles or prostate disease or disorder, or sexually transmitted diseases?
❒	❒	i. Arthritis, lupus, fibromyalgia or other skin, bone, joint or muscle disease or disorder?
❒	❒	j. Any injury, disease, or illness not indicated above?

3. Other than above, have you ever:

❒	❒	a. Within the last 5 years, consulted any other physician or medical practitioner, or had an electrocardiogram (EKG), chest X-ray or any lab test or study?
❒	❒	b. Within the last 5 years, received medical treatment or advice, including medication, or been hospitalized or had surgery?
❒	❒	c. Applied for, or received benefits, because of accident, sickness, or disability?
❒	❒	d. Sought or received treatment for, or been arrested for, the use of alcohol, marijuana, or drugs?
❒	❒	e. Used narcotics, cocaine, LSD, marijuana, amphetamines, or barbiturates, unless administered on the advice of a physician?

4. In the past 10 years have you:

❒	❒	Been diagnosed or treated by a member of the medical profession for immune deficiency disorder, Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC)?

5. Details for questions 2-4. Give details for each YES answer.

Question Number	Condition/Diagnosis	Approximate Dates/Duration	Treatment	Physician Name & Address

Agreement and Authorization

Each person who signs below represents and agrees that the statements and answers recorded on this application are given to obtain this insurance and are true, complete, and correctly recorded. Fraud or material misrepresentation in the application will make this agreement invalid, and Midland National Life Insurance Company's (the "Company") only liability shall be to refund any advance payment made.

The Company will have no liability unless: (a) the application is approved; (b) the first full premium is paid; and (c) the policy is issued and the Owner accepts it. This must be during the lifetime of any person proposed for insurance; also, his or her eligibility and health must remain as described in the application. If these requirements are met, insurance will be in effect on the policy effective date. By accepting the policy, the Owner consents to any changes the Company has made under "Home Office Endorsements," except that changes in the insurance amount, the risk class, or the insurance plan will be made only with the Owner's written consent. Each person who signs below acknowledges that he or she has read and understands this application and has received copies of the Fair Credit Reporting Act Notification, Notice of Insurance Information Practices, and the Medical Information Bureau Notification.

Insurance products and annuities are not a deposit or other obligation of, or guaranteed by a bank, any affiliate of a bank, or savings association, and are not insured by the Federal Deposit Insurance Corporation (FDIC) or any other agency of the United States, a bank, any affiliate of a bank, or savings association, and involve investment risk, including possible loss of value. The approval or disapproval of any extension of credit by the bank or an affiliate is not based on whether or not this insurance is purchased through the bank or through any particular source.

I authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, Medical Information Bureau (MIB), consumer reporting agency, or employer having information available as to diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment of me and any information as to employment, other insurance coverage, or other non-medical information about me to give to the Company or its reinsurers, any and all such information. I authorize all of these sources, except MIB, to give records or knowledge to any agency that the Company employs to collect and transmit such information. The Company will not release any information to any person or organization **except** to reinsuring companies, MIB, or other persons or organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required or as I may authorize later. I understand that I may request to be interviewed in connection with the preparation of an investigative consumer report. I understand that I am entitled to receive a copy of the investigative consumer report upon request. I understand that I may request a copy of this authorization and that a photographic copy will be as valid as the original, and either shall remain in effect for a period of two years from the date signed. I have the right to revoke this authorization by notifying the Company in writing. The Company may rely on my authorization prior to receiving my notice of revocation.

TAXPAYER IDENTIFICATION NUMBER CERTIFICATION – Under penalties of perjury, I certify that the number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and I am not subject to back up withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding.

FRAUD STATEMENT - Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements is/may be guilty of insurance fraud and may be subject to fines and penalties.

_____ Signed at _____

Signature of Proposed Insured *Date* *City* *State*

_____ _____

Signature of Owner (If Owner is corporation, trust or other entity, include title of signee.) *Date*

Agent certification

(1)To the best of my knowledge and belief, the answers given to the questions in this application are full, complete, and true, and there is nothing adversely affecting the insurability of any person proposed for insurance, except as stated in this application; (2) that I gave the Medical Information Bureau Notification, Notice of Insurance Information Practices and Fair Credit Reporting Act Notification to the Proposed Insured; and (3) to the best of my knowledge and belief, the applicant ❒ **does** ❒ **does not** have any existing life insurance or annuities; and the insurance applied for ❒ **does** ❒ **does not** replace existing insurance.

_____ _____ _____

Signature of Agent *Date* *Agent's No.*

AGENT'S REPORT

Name of Business Contact: _____

1. Proposed Insured's Gross Annual Compensation: Salary: _____ Benefits/Bonuses: _____ 2. Additional Income: _____ Source: _____ 3. Case Manager Name: _____	What is the purpose of this Insurance? (Please check all that apply) ❒ Offset Present & Future Benefit Liabilities ❒ Salary Continuation ❒ Deferred Compensation ❒ Incentive Compensation ❒ Split Dollar ❒ Survivor Income ❒ Key Person ❒ Other (Please Describe): _____

Agents Entitled to Commission

Name	Agent Number	% Commission

Special Instructions

MIDLAND NATIONAL
Life Insurance Company
A Member of the Sammons Financial Group

Simplified Issue
Application for Life Insurance

1. Name of Proposed Insured (First, Middle and Last)	Birth date	Birthplace	Sex	Marital Status

2. Residence Address (Street, City, State, Zip)	Social Security No.	Height ft. in.	Weight Lbs.

2a. Secondary Addressee (Name, Street, City, State, Zip)

3. Occupation (Title/Duties) and Gross Annual Compensation $	Hire Date	Telephone # (home): (business):

4a. Owner Name and Address (if Trust, Name and Date of Trust)	4b. Social Security or Tax ID No.	4c. Relationship to Proposed Insured

5a. Beneficiary	5b. Relationship

6a. Plan Applied for	6b. Sub-account (If Applicable)	6c. Death Benefit Option: ❒ 1 Level ❒ 2 Increasing ❒ Other _____

7a. Amount Applied for $	7b. Planned Periodic Premium	7c. Premium Mode ❒ Single ❒ Annual ❒ Other

8. Are you a U.S. citizen? ❒ Yes ❒ No **(complete appropriate questionnaire)**

9a. Do you have any existing annuity contracts or life insurance policies? ❒ No ❒ Yes

9b. Will this insurance replace or change any existing life insurance or annuity contracts? ❒ No ❒ Yes

Please provide dates and details for all "Yes" answers to questions 10-22 below, including diagnosis and/or treatment, and names of medical providers.

Yes	No		Yes	No	
10. ❒	❒	Do you intend to travel outside the U.S. or Canada within the next 2 years? (If "Yes", complete appropriate questionnaire).	17. ❒	❒	Have you had or been treated for diabetes, sleep apnea, kidney or liver disorder, digestive disorder, asthma or other respiratory disorder or depression, mental illness, anxiety or seizure disorder?
11. ❒	❒	Do you participate in or intend to participate in piloting any aircraft, hang-gliding, soaring, sky diving/parachuting, ballooning, motorized vehicle racing, scuba diving, mountain or rock climbing? (If "Yes" complete appropriate questionnaire).	18. ❒	❒	Have you been hospitalized, received surgery or medical treatment, or been diagnosed with any injury, disease or illness not indicated above?
12. ❒	❒	Have you ever had an application for insurance rated, postponed or declined?	19. ❒	❒	In the past 10 years have you been diagnosed or treated by a member of the medical profession for immune deficiency disorder, Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC)?
13. ❒	❒	During the past 6 months, have you missed more than five consecutive days of work due to illness or injury?	20. Name and Address of Physician Last Consulted: _____		
14. ❒	❒	Have you used any tobacco or nicotine product in the past 12 months?	21. Date and Reason Last Consulted: _____		
15. ❒	❒	Have you received treatment or counseling, or been arrested for the use of alcohol or illegal or illegally obtained drugs?	22. List currently prescribed medications: _____ _____		
16. ❒	❒	Have you had or been treated for any heart disorder, stroke, transient ischemic attack (TIA), high blood pressure, cancer, tumor, polyp, blood or immune disorder, breast disorder or prostate disorder?			

If additional space is needed, attach a separate page with details and proposed insured's signature.

MIDLAND NATIONAL LIFE INSURANCE COMPANY
PRINCIPAL OFFICE • WEST DES MOINES, IA 50266
CORPORATE MARKETS CENTER • 2000 44TH STREET SOUTH, STE. 300 • FARGO, ND 58103
PHONE (800) 283-5433 • FAX: (701) 433-8596

Agreement and Authorization

Each person who signs below represents and agrees that the statements and answers recorded on this application are given to obtain this insurance and are true, complete, and correctly recorded. Fraud or material misrepresentation in the application will make this agreement invalid, and Midland National Life Insurance Company's (the "Company") only liability shall be to refund any advance payment made.

The Company will have no liability unless: (a) the application is approved; (b) the first full premium is paid; and (c) the policy is issued and the Owner accepts it. This must be during the lifetime of any person proposed for insurance; also, his or her eligibility and health must remain as described in the application. If these requirements are met, insurance will be in effect on the policy effective date. By accepting the policy, the Owner consents to any changes the Company has made under "Home Office Endorsements," except that changes in the insurance amount, the risk class, or the insurance plan will be made only with the Owner's written consent. Each person who signs below acknowledges that he or she has read and understands this application and has received copies of the Fair Credit Reporting Act Notification, Notice of Insurance Information Practices, and the Medical Information Bureau Notification.

Insurance products and annuities are not a deposit or other obligation of, or guaranteed by a bank, any affiliate of a bank, or savings association, and are not insured by the Federal Deposit Insurance Corporation (FDIC) or any other agency of the United States, a bank, any affiliate of a bank, or savings association, and involve investment risk, including possible loss of value. The approval or disapproval of any extension of credit by the bank or an affiliate is not based on whether or not this insurance is purchased through the bank or through any particular source.

I authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, Medical Information Bureau (MIB), consumer reporting agency, or employer having information available as to diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment of me and any information as to employment, other insurance coverage, or other non-medical information about me to give to the Company or its reinsurers, any and all such information. I authorize all of these sources, except MIB, to give records or knowledge to any agency that the Company employs to collect and transmit such information. The Company will not release any information to any person or organization **except** to reinsuring companies, MIB, or other persons or organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required or as I may authorize later. I understand that I may request to be interviewed in connection with the preparation of an investigative consumer report. I understand that I am entitled to receive a copy of the investigative consumer report upon request. I understand that I may request a copy of this authorization and that a photographic copy will be as valid as the original, and either shall remain in effect for a period of two years from the date signed. I have the right to revoke this authorization by notifying the Company in writing. The Company may rely on my authorization prior to receiving my notice of revocation.

TAXPAYER IDENTIFICATION NUMBER CERTIFICATION – Under penalties of perjury, I certify that the number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and I am not subject to back up withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding.

FRAUD STATEMENT - Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements is/may be guilty of insurance fraud and may be subject to fines and penalties.

Home Office Endorsements

_____ Signed at _____

Signature of Proposed Insured *Date* *City* *State*

_____ _____

Signature of Owner (If Owner is corporation, trust or other entity, include title of signee.) *Date*

Agent certification

(1)To the best of my knowledge and belief, the answers given to the questions in this application are full, complete, and true, and there is nothing adversely affecting the insurability of any person proposed for insurance, except as stated in this application; (2) that I gave the Medical Information Bureau Notification, Notice of Insurance Information Practices and Fair Credit Reporting Act Notification to the Proposed Insured; and (3) to the best of my knowledge and belief, the applicant ❒ **does** ❒ **does not** have any existing life insurance or annuities; and the insurance applied for ❒ **does** ❒ **does not** replace existing insurance.

_____ _____ _____

Signature of Agent *Date* *Agent's No.*

AGENT'S REPORT

Name of Business Contact: _____

1. Proposed Insured's Gross Annual Compensation: Salary: _____ Benefits/Bonuses: _____ 2. Additional Income: _____ Source: _____ 3. Case Manager Name: _____	What is the purpose of this Insurance? (Please check all that apply) ❒ Offset Present & Future Benefit Liabilities ❒ Salary Continuation ❒ Deferred Compensation ❒ Incentive Compensation ❒ Split Dollar ❒ Survivor Income ❒ Key Person ❒ Other (Please Describe): _____

Agents Entitled to Commission

Name	Agent Number	% Commission

Special Instructions

MIDLAND NATIONAL
Life Insurance Company
A Member of the Sammons Financial Group

Application for Policy Reinstatement or Change

1. Name of Insured (First, Middle and Last)	Birth date	Birthplace	Sex	Marital Status

2. Residence Address (Street, City, State, Zip)	Social Security No.	Height ft. in.	Weight lbs.

3. Policy Number	4. Occupation / Title and Gross Annual Compensation $	Telephone # (home): (business):

5a. Owner Name and Address	5b. Social Security or Tax ID No.
	5c. Relationship to Proposed Insured

6. Policy Change requested:

❒ Reconsideration of Rate Class ❒ Reinstatement

❒ Other: _____

7. Life Insurance and annuities in force and pending: If None, check here: ❒

Company	Policy #	Personal or Business	Pending	Issue Year	Benefit Amount	ADB Amount	WP Amount	Intention of Replacement or Change
			❒					❒ Y ❒ N
			❒					❒ Y ❒ N
			❒					❒ Y ❒ N
			❒					❒ Y ❒ N
			❒					❒ Y ❒ N
			❒					❒ Y ❒ N

Provide details for all "Yes" answers to questions 8-17 below.

Yes	No		
❒	❒	8.	Are you a U.S. citizen? **(If "No", complete appropriate questionnaire.)**
❒	❒	9.	Do you intend to travel outside the U.S. or Canada within the next 2 years? **(If "Yes", complete appropriate questionnaire.)**
❒	❒	10.	Do you participate in or do you intend to participate in aviation related sports, powered or competitive vehicle racing, sky or scuba diving, mountain climbing, or any other hazardous sport or activity? **(If "Yes", complete appropriate questionnaire.)**
❒	❒	11.	Have you ever been convicted of, or are you awaiting trial for, a felony?
❒	❒	12.	Have you ever had an application for insurance declined, postponed or rated?
		13.	Your driver's license #: _____ State: _____

Yes	No		
		14.	Within the past 10 years, have you been convicted of or pled guilty to:
❒	❒		a) Moving violations?
❒	❒		b) Driving under the influence of alcohol and/or drugs?
❒	❒	15.	Have you been a pilot or crew member during the past 3 years or have any intention of becoming a pilot, student pilot, or crew member in any type of aircraft? **(If "Yes", complete appropriate questionnaire.)**
		16.	Have you ever used:
❒	❒		a) Cigarettes? Date last used: _____
❒	❒		b) Other nicotine products: Date last used: _____
❒	❒	17.	Do you have any family history of heart disease, cancer, high blood pressure, diabetes, hemophilia, Huntington's chorea, polycystic kidney disease or any congenital disorder?

Details for questions 8-17:

1a. Name and address of Personal Physician:

1b. Date and reason last consulted:

1c. Name and Address of physician **most recently** consulted if different than above:

1d. Date and reason for most recent consultation:

1e. List any currently prescribed medications:

2. Have you ever had or been treated for:

Yes	No	
❒	❒	a. Elevated cholesterol, high blood pressure, transient ischemic attack (TIA), stroke or circulation disorder?
❒	❒	b. Chest pain, heart attack, heart murmur, irregular heart rate, or other disease or disorder of the heart?
❒	❒	c. Cancer, tumor, polyp, blood or immune system disease or disorder?
❒	❒	d. Diabetes, kidney, or urinary disease or disorder?
❒	❒	e. Crohn's disease, colitis, ulcer, diverticulitis, hepatitis, or any disease of the esophagus or liver?
❒	❒	f. Sleep apnea, asthma, emphysema, lung or respiratory disease or disorder?
❒	❒	g. Depression, mental illness, anxiety or seizure disorder?
❒	❒	h. Breast, uterus, ovaries, testicles or prostate disease or disorder, or sexually transmitted diseases?
❒	❒	i. Arthritis, lupus, fibromyalgia or other skin, bone, joint or muscle disease or disorder?
❒	❒	j. Any injury, disease, or illness not indicated above?

3. Other than above, have you ever:

❒	❒	a. Within the last 5 years, consulted any other physician or medical practitioner, or had an electrocardiogram (EKG), chest X-ray or any lab test or study?
❒	❒	b. Within the last 5 years, received medical treatment or advice, including medication, or been hospitalized or had surgery?
❒	❒	c. Applied for, or received benefits, because of accident, sickness, or disability?
❒	❒	d. Sought or received treatment for, or been arrested for, the use of alcohol, marijuana, or drugs?
❒	❒	e. Used narcotics, cocaine, LSD, marijuana, amphetamines, or barbiturates, unless administered on the advice of a physician?

4. In the past 10 years have you:

❒	❒	Been diagnosed or treated by a member of the medical profession for immune deficiency disorder, Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC)?

5. Details for questions 2-4. Give details for each YES answer.

Question Number	Condition/Diagnosis	Approximate Dates/Duration	Treatment	Physician Name & Address

Agreement and Authorization

Each person who signs below represents and agrees that the statements and answers recorded on this application are given to obtain this insurance and are true, complete, and correctly recorded. Fraud or material misrepresentation in the application will make this agreement invalid, and Midland National Life Insurance Company's (the "Company") only liability shall be to refund any advance payment made.

It is agreed that the Policy will not be reinstated or a change will not be effected, and the Company will have no liability until: (a) this application is approved; and (b) all money required for reinstatement and/or change has been paid. This must be during the lifetime of any person proposed for insurance; also, his or her eligibility and health must remain as described in this application. If these requirements are met, insurance will be in effect on the effective date of the reinstatement or change. By accepting the reinstated policy or changed policy, the Owner consents to any changes the Company has made under "Home Office Endorsements," except that changes in the insurance amount, the risk class, or the insurance plan will be made only with the Owner's written consent. Each person who signs below acknowledges that he or she has read and understands this application and has received copies of the Fair Credit Reporting Act Notification, Notice of Insurance Information Practices, and the Medical Information Bureau Notification.

I authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, Medical Information Bureau (MIB), consumer reporting agency, or employer having information available as to diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment of me and any information as to employment, other insurance coverage, or other non-medical information about me to give to the Company or its reinsurers, any and all such information. I authorize all of these sources, except MIB, to give records or knowledge to any agency that the Company employs to collect and transmit such information. The Company will not release any information to any person or organization **except** to reinsuring companies, MIB, or other persons or organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required or as I may authorize later. I understand that I may request to be interviewed in connection with the preparation of an investigative consumer report. I understand that I am entitled to receive a copy of the investigative consumer report upon request. I understand that I may request a copy of this authorization and that a photographic copy will be as valid as the original, and either shall remain in effect for a period of thirty months from the date signed. I have the right to revoke this authorization by notifying the Company in writing. The Company may rely on my authorization prior to receiving my notice of revocation.

Insurance products and annuities are not a deposit or other obligation of, or guaranteed by a bank, any affiliate of a bank, or savings association, and are not insured by the Federal Deposit Insurance Corporation (FDIC) or any other agency of the United States, a bank, any affiliate of a bank, or savings association, and involve investment risk, including possible loss of value. The approval or disapproval of any extension of credit by the bank or an affiliate is not based on whether or not this insurance is purchased through the bank or through any particular source.

TAXPAYER IDENTIFICATION NUMBER CERTIFICATION – Under penalties of perjury, I certify that the number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and I am not subject to back up withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding.

FRAUD STATEMENT – Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements is/may be guilty of insurance fraud and may be subject to fines and penalties.

Home Office Endorsements.

Signed at _____ Date _____
City *State*

_____
Signature of Proposed Insured

_____
Signature of Owner (If Owner is corporation, trust or other entity, include title of signee.)

Agent certification

(1)To the best of my knowledge and belief, the answers given to the questions in this application are full, complete, and true, and there is nothing adversely affecting the insurability of any person proposed for insurance, except as stated in this application; (2) that I gave the Medical Information Bureau Notification, Notice of Insurance Information Practices and Fair Credit Reporting Act Notification to the Proposed Insured; (3) to the best of my knowledge and belief, the applicant ❒ **does** ❒ **does not** have any existing life insurance or annuities; and, the insurance applied for ❒ **does** ❒ **does not** replace existing insurance.

_____ _____ _____
Signature of Agent *Date* *Agent's No.*

MIDLAND NATIONAL®
Life Insurance Company
A Member of the Sammons Financial Group

STATEMENT OF HEALTH AND INSURABILITY

Name of Proposed Insured: _____ Policy Number(s): _____

Since the date of the original application:	YES	NO
1. have you consulted or been treated by any physician or practitioner or had any physical disability or impairment, sickness, injury, surgery or mental disorder?	☐	☐
2. have you had a physical examination, lab tests, EKG or X-ray procedures?	☐	☐
3. have you used tobacco in any form? If yes, give form used and date last used in "Details".	☐	☐
4. have you made an application for insurance which has been declined, postponed or modified?	☐	☐
5. do you have any other applications for insurance pending with another company(ies) at this time?	☐	☐
6. have you changed occupation? If yes, give current occupation (employer name and duties) in "Details".	☐	☐
7. have you engaged in or expect to engage in any of the following: aviation activities as a pilot or crew member; scuba diving; automobile, motorcycle, or motor boat racing; mountain climbing; rodeo competition; sky-diving or other hazardous activities?	☐	☐

If any question above is answered "Yes", please explain in the "Details" section.

DETAILS:

Question Number	Date	Detail

Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements is/may be guilty of insurance fraud and may be subject to fines and penalties.

I hereby agree that all of the statements above are true to the best of my knowledge and belief. A copy of this form will be attached to and made a part of my application for insurance.

Signature of proposed insured _____ Date _____

MIDLAND NATIONAL LIFE INSURANCE COMPANY
PRINCIPAL OFFICE • WEST DES MOINES, IA 50266
CORPORATE MARKETS CENTER • 2000 44TH STREET SOUTH, STE. 300 • FARGO, ND 58103
PHONE (800) 283-5433 • FAX: (701) 433-8596

SERFF Tracking Number:	*NALH-126380103*	*State:*	*Arkansas*
Filing Company:	*Midland National Life Insurance Company*	*State Tracking Number:*	*44115*
Company Tracking Number:	*FORM 81-36 (10-09) ET AL*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Form 81-36 (10-09) et al*		
Project Name/Number:	*Form 81-36 (10-09) et al/Form 81-36 (10-09) et al*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

Rule & Regulation 19 certification attached.

Rule & Regulation 49 does not apply to application forms.

Flesch Certification attached.

Bulletin 15-2009 replaces Bulletin 11-99 and does not apply to application forms.

Attachments:

81-36 et al readability.pdf

81-36 et al AR Cert.pdf

Item Status: **Status Date:**

Satisfied - Item: Application

Comments:

Applications submitted for approval on Form Schedule.

Item Status: **Status Date:**

Satisfied - Item: Form 81-57 (10-09), Consumer Notices

Comments:

Fair Credit Reporting Act Notification, Notice of Insurance Information Practices and the Medical Information Bureau Notification provided to the applicant at the time of application

Attachment:

Form 81-57 _10-09_.pdf

READABILITY CERTIFICATE

Name and Address of Insurer

Midland National Life Insurance Company
Corporate Markets Center
2000 44th Street South, Ste. 300 Fargo, ND 58103

I hereby certify that Readability has been tested under the Flesch Readability formula set forth by Rudolph Flesch in his book, The Art of Readability Writing and that the form(s) listed below meet your minimum readability requirements of your state.

FORM NUMBER	DESCRIPTION	SCORE
Form 81-36 (10-09)	Regular Issue Application for Life Insurance	50.8
Form 81-38 (10-09)	Simplified Issue Application for Life Insurance	50.3
Form 81-47 (10-09)	Application for Policy Reinstatement or Change	50.9
Form 81-48 (10-09)	Statement of Health and Insurability	53.3

Signature

Joseph E. Paul, FSA, MAAA
Typed Name

Vice President – Corporate Markets Operations
Title

November 10, 2009
Date

TO: Arkansas Department of Insurance

FROM: Midland National Life Insurance Company

DATE: November 17, 2009

RE: Form 81-36 (10-09), Form 81-38 (10-09), Form

Midland National Life Insurance Company certifies that the referenced forms comply with Arkansas Regulation 19 § 10B regarding unfair sex discrimination in insurance.

Carmen R. Walter

Carmen R. Walter, FSA, MAAA
Director of Product Development
Corporate Markets
Midland National Life Insurance Company

Date: November 17, 2009

MIDLAND NATIONAL®
Life Insurance Company
A Member of the Sammons Financial Group

Leave with Applicant

Fair Credit Reporting Act Notification

As part of Midland National Life Insurance Company's normal procedure of processing applications, we may obtain an investigative consumer report concerning such information as to your character, general reputation, and personal characteristics, except as may be related directly or indirectly to your sexual orientation. We will obtain this information through interviews with your friends, neighbors, and associates. You may make a written request to be personally interviewed when such a report is being prepared. You have the right to make a written request to receive a copy of the investigative consumer report. Further information on the nature and scope of the report, if one is made, is available upon request from Midland National Life Insurance Company.

Notice of Insurance Information Practices

You are our most important source of information, but personal information may also be collected from other persons. Such information, as well as other personal or privileged information our agent or we subsequently collect, may, in certain circumstances, be disclosed to third parties without your authorization.

We have established procedures to give you access to all personal information collected. You may request correction of such information in our files that you believe to be inaccurate.

We will provide a more complete description of the information practices of Midland National Life Insurance Company upon your request, in accordance with the requirements of the Insurance Information and Privacy Protection Law in effect in your state of residence.

Medical Information Bureau Notification

Information regarding your insurability will be treated as confidential. Midland National Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. Midland National Life Insurance Company or its reinsurers may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Midland National Life Insurance Company • Corporate Markets Center • 2000 44th St. S. Suite 300 • Fargo, ND 58103
(800) 283-5433 • Fax (701) 433-8596 • www.mnlife.com